		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155226	B. WING		06/20/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
NODTU /	CADITOL NILIDOINO	& REHABILITATION CENTER		CAPITOL AVE APOLIS, IN46202	
				AI OLIO, IIV#UZUZ	1
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DATE
F0000					
10000					
	This visit was for Recertification and		F0000	The creation and submission of plan of correction does not cons	
	State Licensure Survey.			an admission by this provider of	
				conclusion set forth in the stater	
	Survey Dates: June 13, 14, 15, 16, 17 & 20, 2011			of deficiencies, or of any violati	on of
				regulation.	
				This provider respectfully reque	
	Facility Number: 000131 Provider Number: 155226 Aim Number: 100274910			that the 2567 plan of correction	
				considered the letter of credible allegation and requests a Desk	
				review on or after 07/05/11.	
	, ,	10027 1010			
	Survey Team:				
	Diana Zgonc RN T	гс			
	Connie Landman I				
	Courtney Hamiltor				
	Christi Davidson F				
	Offitsti Davidsoff is	W.			
	Census Bed Type	:			
	SNF/NF: 90				
	SNF: 24				
	Total: 114				
	10(a).				
	Census Payor Typ	De:			
	Medicare: 24				
	Medicaid: 81				
	Other: 9				
	Total: 114				
	13tai. 114				
	Sample: 31 S	Stage 2			
	Sample. 31 S	olaye 2			
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155226		(X2) MULTIPI A. BUILDING B. WING	(RUCTION 00	(X3) DATE S COMPL 06/20/2	ETED	
	PROVIDER OR SUPPLIER	& REHABILITATION CENTER	201	10 N CAI	RESS, CITY, STATE, ZIP CODE PITOL AVE OLIS, IN46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	0	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	These deficiencies findings cited in ad IAC 16.2. Quality review cor Cathy Emswiller F	ecordance with 410					
F0323 SS=D	environment remain hazards as is possible receives adequated devices to prevent Based on observal and interview, the ensure the environmemory care unit accident hazards reflect 22 residents. Findings include; During an observation of the province of the possible remains the possi	tion, record review facility failed to ment in the locked was free from with the potential to s. tion on 06/14/11 at 0:35 a.m., a set of d hanging from the it elevator across the elevator doors	F0323	I e e f f e e s s f f e e s s f f e e e s f f e e e e	It is the practice of this provider ensure that residents environme free of accident hazards and that each resident receives adequate supervision and assistive device prevent accidents. What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: Keys were removed at time of discovery, a staff stayed next to elevator to each that it had not been sent up to the unit. Memory care facilitator disminediate head count of resident init to ensure that none had left unit.	nt be t es to e s the nd ensure ne id an nts on	07/05/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155226 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2010 N CAPITOL AVE NORTH CAPITOL NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE accessed the memory care unit on How will you identify other residents the third floor of the facility. having the potential to be affected by the same deficient practice and what corrective action will be taken: All During an observation on 06/14/11 residents who reside on the Augustes from 10:25 a.m. until 10:29 a.m., the Cottage memory care unit have the potential to be affected by this keys went unnoticed by LPN #7 and alleged deficient practice. Activities Staff Member #8 that walked by these elevator doors. What measures will be put into place During an observation on 06/14/11 at or what systemic changes you will 10:31 a.m., the DoN entered the unit make to ensure that the deficient practice does not recur: All staff that and walked past the keys. have access to or utilize the elevator access keys to the memory care unit will be inserviced by the Staff During an observation on 06/14/11 at Development Coordinator on use and 10:35 a.m., the DoN saw the keys on removal of keys for elevator access. her way to exit the unit. The DoN questioned the staff to identify who the keys belonged to. No staff on the How the corrective action(s) will be unit claimed the keys. The DoN monitored to ensure the deficient practice will not recur: Customer called the housekeeping staff #12. Care rounds audit sheet will be used by the Department Directors, or During an observation on 06/14/11 at designee, as the monitoring CQI tool. CQI tool will be completed weekly 10:39 a.m., the housekeeping staff x4, monthly x2, then quarterly #12 and housekeeper #11 entered thereafter until the threshold is met. the unit through the elevator doors where the keys were left. During an interview with the DoN on 06/14/11 at 10:40 a.m., the DoN indicated the housekeeping staff #12

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155226		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 06/20/2	ETED	
	PROVIDER OR SUPPLIER	& REHABILITATION CENTER	p. wind	STREET A	DDRESS, CITY, STATE, ZIP CODE CAPITOL AVE APOLIS, IN46202	<u>I</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	would address the housekeeper #11.						
	A One-on-One Indated 05/02/11 incohousekeeper #11 on operating the ememory care unit.	dicated had been educated levator on the					
	During an interview 06/20/11 at 9:25 a indicated there we the memory care u	.m., the DoN re 22 residents on					
	Supervisor #9 on 0	ance Supervisor #9 cted the keys to be elevator when a					
	σ. · · · · · · · · · · · · · · · · · · ·						

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	(X2) MULTIPLE CO A. BUILDING B. WING	00	1 1	e survey pleted /2011
	PROVIDER OR SUPPLIER	& REHABILITATION CENTER	2010 N	ADDRESS, CITY, STATE, ZIP CO CAPITOL AVE IAPOLIS, IN46202	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE

000131

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nic	00	COMPL	ETED
		155226	A. BUILD	ING		06/20/2	011
			B. WING				
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					CAPITOL AVE		
NORTH (CAPITOL NURSING	& REHABILITATION CENTER		INDIAN	APOLIS, IN46202		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	·			TAG	DEFICIENCY)		DATE
F0334		evelop policies and					
SS=C	procedures that er						
		the influenza immunization,					
	each resident, or t						
	•	eives education regarding					
	•	otential side effects of the					
	immunization;	a offered an influence					
	· ·	s offered an influenza ober 1 through March 31					
		ne immunization is medically					
		the resident has already					
		luring this time period;					
		r the resident's legal					
	representative has the opportunity to refuse						
	immunization; and	* * * * * * * * * * * * * * * * * * *					
	·	medical record includes					
		at indicates, at a minimum,					
	the following:						
	(A) That the resid	dent or resident's legal					
	representative was	s provided education					
	regarding the bene	efits and potential side					
	effects of influenza	a immunization; and					
	` '	dent either received the					
		ation or did not receive the					
		ation due to medical					
	contraindications of	or refusal.					
	The facility must d	evelop policies and					
	procedures that er						
	•	the pneumococcal					
		th resident, or the resident's					
		ve receives education					
		efits and potential side					
	effects of the immi						
		s offered a pneumococcal					
	` '	ess the immunization is					
		dicated or the resident has					
	already been immunized;						
	· '	r the resident's legal					
	representative has	s the opportunity to refuse					
	immunization; and	l					
	(iv) The resident's	medical record includes					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155226 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2010 N CAPITOL AVE NORTH CAPITOL NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. F0334 F 334 07/05/2011 Based on record review and It is the practice of this provider to interview, the facility failed to ensure 3 offer the influenza immunization annually from October 1 through of 5 residents or resident's legal March 31, it is also the policy that representatives reviewed for Influenza the resident or the residents legal and pneumococcal immunizations representative be provided with education on the benefits and received education, information or an potential side effects, and have the opportunity to refuse the opportunity to accept or decline the immunization each time the vaccine annually. It is also the practice of this facility to offer each immunization was administered out of resident the pneumococcal vaccine, a total stage two sample of 31. (#99, to provide the resident or the #112, #113) residents legal representative with education regarding the benefits and potential side effects of the Findings included: pneumococcal vaccine, and the opportunity to accept or decline the vaccine. 1. The record for Resident #99 was reviewed on 06/16/11 at 10:03 a.m. What corrective action(s) will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155226 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2010 N CAPITOL AVE NORTH CAPITOL NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE accomplished for those residents found to have been affected by the Diagnoses included, but were not alleged deficient practice? For all limited to, Alzheimer's dementia, residents who had not received influenza vaccine or pneumococcal ataxia, hypertension, vitamin D vaccine their responsible parties and deficiency and a history of alcohol physicians were notified, and consent or declination was received after abuse education was provided to families. All residents for whom consents A recapitulation, dated for the month were received the vaccines were administered. of June 2011, indicated Resident #99 may have yearly mantoux (tuberculosis) and flu (influenza) How will you identify other residents having the potential to be vaccine. affected by the same alleged deficient practice and what corrective action will be taken. A recapitulation for Resident #99, Each residents medical record will be dated for the month of June 2011, audited for consent or declination in with a current physician's order the previous calendar year to determine residents who have the indicated, "... May have Pneumovax potential to be affected by this 5/2/11...." alleged deficient practice. A vaccination record for Resident What measures will be put into #99, indicated, "...11/1/10 Flu Vac place or what systemic changes {Influenza vaccine}...5/16/11 vou will make to ensure that the alleged deficient practice does not Pneumovac {Pneumococcal recur. Each resident will have vaccine \ " pneumococcal re-offered, along with education provided to responsible parties. A consent/declination for The record for Resident #99 lacked current calendar year will be documentation of a pneumococcal or obtained. All residents with new consent will have physician influenza immunization consent form contacted, and immunization for 2010 or 2011. administered. Beginning September 1, 2011 facility staff will begin

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155226		LDING	00	06/20/2	
		100220	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF I	PROVIDER OR SUPPLIE	₹			CAPITOL AVE		
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER		1	APOLIS, IN46202		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	contacting responsible parties in		DATE
	The record for Resident #112 was				anticipation of the upcoming	1	
	reviewed on 06/10	6/11 at 2:27 p.m.			influenza season, provide educa	ition,	
					and obtain new consent or		
	Diagnoses include	ed, but were not			declination. All residents with current consent will receive	a	
	limited to, aphasia	a, dysphagia,			vaccinations between October 1		
	hypertension, cerebral vascular				2011 through March 31, 2012.	2	
	accident and lung	nodule.					
					How the corrective action(s) v	vill	
	A recapitulation, dated for the month				be monitored to ensure the	VIII	
					deficient practice will not recu	r?	
	of June 2011, indicated Resident				i.e., what quality assurance		
	#112 may have yearly flu and				program will be put into place CQI tool will be utilized weekly		
	mantoux vaccine.				compliance is reached, and ther		
					monthly. ****Beginning in		
	A vaccine record	for Resident #112,			September the CQI tool will be		
	indicated, "11/3	1/10 Flu			completed weekly until compliant is reached, and then monthly the		
	Vac5/31/11 Pne	eumovax"			March 31, 2012 by the DNS or		
					designee.		
	The record for Re	sident #112 lacked					
	documentation of	a pneumococcal or					
	influenza immuniz	zation consent form					
	for 2010 or 2011.						
	3. The record for	Resident #113 was					
	reviewed on 06/17	7/11 at 8:28 a.m.					
	Diagnoses include	ed, but were not					
	limited to, chronic	obstructive					
	pulmonary diseas	e, dementia,					
	gastrointestinal re	flux disease, and					
	seizure disorder.						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETE	
		155226	B. WINC			06/20/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NORTH (CAPITOL NURSING	& REHABILITATION CENTER			CAPITOL AVE APOLIS, IN46202		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OMPLETION DATE
1710	REGGE/HORT OR	ESC IDENTIFY TING INFORMATION)	+	ing	·		DATE
	A recapitulation, d	ated for the month					
	of June, indicated	Resident #113 may					
	have yearly flu, pn	eumonia and					
	mantoux vaccine.						
	A vaccine record f	or Resident #113,					
	indicated, "10/11	I/10 Flu Vac per					
	Hosp {hospital}1	0/11/10					
	Pneumovac per Hos"						
	The record for Res	sident #113 lacked					
	documentation of	a pneumococcal or					
	influenza immuniz	ation consent form					
	for 2010 or 2011.						
	During an interviev	w with the DoN on					
	06/16/11 at 2:40 p	.m., the DoN					
	indicated, there ha	ave been changes in					
	the medical record	ls department. The					
	DoN indicated the	re was a binder that					
	maintained all yea	rly pneumococcal					
	and influenza cons	sents for each					
	resident. The DoN	indicated she					
	would provide the	binder in the a.m.					
	During an interviev	w with the DoN on					
	06/17/11 at 11:10	a.m., the DoN					
	provided the binde	er with consents.					
	The DoN indicated	d she did not get					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155226			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155226	B. WIN			06/20/2	U11
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE CAPITOL AVE		
NORTH (CAPITOL NURSING	& REHABILITATION CENTER		1	APOLIS, IN46202		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		h year because of	+				5.112
	the wording of the						
	the wording of the	lacility consent.					
	The binder contained an influenza						
	consent for Reside	ent # 99 dated					
	10/28/08 and a pn	eumococcal					
	immunization cons	sent for Resident					
	#99 dated 09/04/0	8.					
	The binder contained an influenza						
	consent for Resident #112 dated						
	06/25/09 and a pn	eumococcal					
	immunization cons	sent for Resident					
	#112 dated 06/25/	/09.					
	The binder contair	ned an influenza					
	consent for Reside	ent #113 dated					
	08/03/09 and a pn	eumococcal					
	immunization cons	sent for Resident					
	#113 dated 08/03/	709.					
	No further consent	ts were provided for					
	Residents #99, #1	12 or #113.					
	3.1-13(a)						

NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & (X4) ID SUMMARY STAT	55226	2010 N	ADDRESS, CITY, STATE, ZIP CODE I CAPITOL AVE NAPOLIS, IN46202	COMPLETED 06/20/2011
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & (X4) ID SUMMARY STAT	REHABILITATION CENTER FEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL	STREET 2010 N INDIAI	I CAPITOL AVE	06/20/2011
NORTH CAPITOL NURSING & (X4) ID SUMMARY STAT	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL	2010 N INDIAI	I CAPITOL AVE	
(X4) ID SUMMARY STAT	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL	INDIAI		
(X4) ID SUMMARY STAT	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL	ID	NAI OLIO, IIN40202	
	MUST BE PERCEDED BY FULL		+	
(Exchibilitetere i			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR LSC		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
considered satisfacto local authorities; and	istribute and serve food tions In, record review, cility failed to vashed their and 20 seconds Ig meal service for rees observed for (Food Service Dietary Aide] #4, In This practice affect 108 of 114 Ity. In the service, at 12:00 P.M., poty pan from the red it in the 3 rent to the hand ashed her hands ok #5 then went	F0371	F 371 It is the practice of this provided procure food from sources appror or considered satisfactory by festate or local authorities, and to prepare, and distribute and servifood under sanitary conditions. What corrective action(s) will accomplished for those resider found to have been affected by alleged deficient practice? All dietary staff was reinstructed or washing practices by Registered Dietitian on 6/30/11. How will you identify other residents having the potential affected by the same alleged deficient practice and what corrective action will be taken residents who receive food or fl from facility kitchen have the possibility to be affected by this alleged deficient practice. What measures will be put int	oved deral, store, e be nts v the n hand d to be . All uids

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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07/08/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155226 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2010 N CAPITOL AVE NORTH CAPITOL NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46202 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE place or what systemic changes again started serving food. FSS #3 you will make to ensure that the was observed leaving the kitchen, alleged deficient practice does not returning a minute later and took food recur. All dietary personal will be re-inserviced on hand washing from the oven to the steam table. standards and food handling FSS #3 then washed her hands for 10 practices. All dietary staff will have a hand washing skills validation seconds and began going in and out completed by Registered Dietician. of the walk-in refrigerator, heating soup in the microwave, dipping How the corrective action(s) will applesauce, taking sandwiches from be monitored to ensure the the oven to the steam table, cooking deficient practice will not recur? grilled cheese sandwiches, and taking i.e., what quality assurance program will be put into place. french fries from the oven to the **** CQI hand washing monitoring steam table. DA #4 was observed tool will be completed by the Registered Dietician weekly x4, placing plastic wrap from dessert monthly x2, and quarterly thereafter dishes into the trash can, which she until threshold has been met. had touched to open the lid, washing her hands for 10 seconds before returning to placing desserts and silverware on trays.. DA #6 was observed throwing a paper towel she had picked up off the floor into the trash, then washed her hands for 12 seconds before returning to the tray line. A current facility policy, dated 5/06, provided by the Administrator on 6/14/11 at 8:20 A.M., titled "Food Handling Policy" indicated: "... Procedure:

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If continuation sheet

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155226		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMP 06/20/2	LETED
	PROVIDER OR SUPPLIE		B. WIN	2010 N	ADDRESS, CITY, STATE, ZIP CODE CAPITOL AVE APOLIS, IN46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Food employe	es (any individual					
	working with food	, food equipment or					
	utensils, or food-o	contact surfaces) will					
	clean their hands	and exposed					
	portions of their a	rms before engaging					
	in food preparatio	n including working					
	with exposed food	d, clean equipment					
	and utensils, and	unwrapped					
	single-service and single-use articles						
	and:						
	c) After handling soiled surfaces,						
	equipment or uter	nsils;.					
	e) Directly before	ore touching					
	ready-to-eat food	or food-contact					
	surfaces;"						
	The current facilit	y policy lacked					
	documentation of	an amount of time					
	to wash hands.						
	During an intervie	ew with the DON					
	(Director of Nursi	ng) on 6/17/11 at					
	8:30 A.M., she ind	dicated 108					
	residents in the fa	acility received meals					
	from the kitchen,	the other 6 residents					
	were not receiving	g oral food or fluids.					
	During an intervie	ew with the Dietician					
	on 6/15/11 at 8:00	0 A.M., she indicated					
	the expectation w	as the kitchen staff					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THEFTERN	or connection	155226	A. BUILDING B. WING		06/20/2011
NAME OF D	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				CAPITOL AVE	
		& REHABILITATION CENTER		APOLIS, IN46202	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	would wash their h	nands for at least 20			
	seconds.				
	3.1-21(i)(3)				
F0425	The facility must p				
SS=D		and biologicals to its n them under an agreement			
	described in §483.	.75(h) of this part. The			
		unlicensed personnel to f State law permits, but only			
	under the general	supervision of a licensed			
	nurse.				
	•	vide pharmaceutical			
		g procedures that assure the g, receiving, dispensing, and			
	administering of al	ll drugs and biologicals) to			
	meet the needs of	each resident.			
		mploy or obtain the services			
		macist who provides aspects of the provision of			
	pharmacy services				
	Based on observa	tion and interview,	F0425	F 425 It is the practice of this provider	07/05/2011
	the facility failed to	ensure insulin was		provide routine, and emergency	
	not expired in 1 of	6 med carts		drugs and biologicals to the	
					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/20/2011	
	PROVIDER OR SUPPLIER	S & REHABILITATION CENTER	B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE CAPITOL AVE APOLIS, IN46202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
TAG	regulatory or checked for expired checked for	d medications. medication cart on unit on 06/17/2011 an open vial of there was no open the fill date on the 2011. titled, "48.03 Guide thin" provided by the g (DON) on 50 A.M., indicated thened vial of Lantus LPN #2 on M. indicated she		TAG	residents. It is also the practice this facility to provide pharmaceutical services, includ procedures that assure the accur acquiring, receiving, dispensing administering of all drugs and biologicals to meet the needs of resident. What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice: The insulinity was potentially expired was rem from the medication cart, and replaced with a previously unopvial. How will you identify other residents who receive insulining the potential to be affected by the alleged deficient practice. Each medication cart was checked immediately during the survey process by the unit managers to ensure that they did not contain expired insulin. What measures will be put into or what systemic changes you waske to ensure that the deficient.	of ing rate g, and reach e s the chat hoved bened idents ed by what All tive his any place vill t
					practice does not recur: All lice nurses or QMA's were reinservi on 6/30/11 by the Staff Develop Coordinator on the labeling, sto and expiration dates of insulin.	ced oment

Facility ID:

PRINTED: 07/08/2011 FORM APPROVED OMB NO. 0938-0391

l	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 06/20/2	LETED		
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN46202					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	BE	(X5) COMPLETION DATE		
F0431 SS=D	of a licensed phant system of records all controlled druggenable an accurate determines that druggenable an account of maintained and permanently affixed of control Act of 197 abuse, except will enable all control act of 197 abuse, except will enable all control act of 197 abuse, except will enable all control act of 197 abuse, except whe unit package drug which the gracular determines all control act of 197 abuse, except whe unit package drug which the quantity	mploy or obtain the services macist who establishes a of receipt and disposition of in sufficient detail to e reconciliation; and ug records are in order and all controlled drugs is eriodically reconciled. Cals used in the facility must rdance with currently onal principles, and include cessory and cautionary he expiration date when In State and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only nel to have access to the Tovide separately locked, and compartments for storage is listed in Schedule II of the rug Abuse Prevention and and other drugs subject to the facility uses single distribution systems in stored is minimal and a be readily detected.		How the corrective action(s) monitored to ensure the defi practice will not recur: Med storage review CQI tool wil utilized weekly x4, monthly then quarterly thereafter, to completed by DNS or designate the complete of the	cient ication I be x2, and be			

000131

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
155226		B. WING 06/20/20			06/20/2011		
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				2010 N	CAPITOL AVE		
NORTH CAPITOL NURSING & REHABILITATION CENTER			INDIANAPOLIS, IN46202				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL				CROSS-REFERENCED TO THE APPROPRIAT		
TAG		tion and interview	F0	431	F 431	07/05/2011	
	Based on observation and interview, the facility failed to ensure opened vials of insulins contained open dates				It is the practice of this provider	r to	
					have drugs and biologicals labe accordance with currently accept		
					professional principles, and incl		
	in 1 of 6 med carts checked for			the appropriate accessory and			
	expired and dated	medications.			cautionary instructions, and the	l l	
					expiration date when applicable		
	Findings include:				What corrective action(s) will b	e	
					accomplished for those resident		
	Observation of the	e medication cart on			found to have been affected by		
	the 3rd floor vent i	ınit on 06/17/2011			deficient practice: All medicati		
	the 3rd floor vent unit on 06/17/2011 at 9 A.M. indicated 3 open vials of		carts were inspected and insulin which did not have open dates were immediately removed from the		_		
					vere		
	Lantus, Humalog	and Novolin			medication cart and replaced.		
	(insulins). The vials did not contain						
	open dates.				How will you identify other res.		
					having the potential to be affect	· I	
	An undated policy	titled "48.03 Guide			the same deficient practice and corrective action will be taken:		
	for Storage of Insulin" provided by the facility on 06/17/2011 at 10:50 A.M., lacked documentation of procedures for dating open insulin vials.				residents who receive insulin ha		
					the potential to be affected by the		
					alleged deficient practice. Each medication cart was checked to		
					ensure that they did not contain		
	The policy indicate				insulin without labeled open dat	· I	
	dates for the open	•					
	·	28 days" and "30			What measures will be put into	place	
	_	-			or what systemic changes you v	vill	
	days" for the Novo	olin.			make to ensure that the deficien		
					practice does not recur: All lice	l l	
	An interview with L	_PN #2 on			nurses or QMA's were reinservi by the Staff Development	cea	
	06/17/2011 at 9 A	.M. indicated she			Coordinator on 6/30/11 on the		
	would dispose of t	he insulin.			labeling, storage, and expiration		
					dates of insulin. Any insulin for		
	3.1-25(o)				without an open date or expirati	on	
	5.1 20(0)				<u> </u>		

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		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION				DING	00	COMPLETED 06/20/2011		
		155226	B. WING			06/20/2	011	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 2010 N. CARITOL AVE								
NORTH CAPITOL NURSING & REHABILITATION CENTER			2010 N CAPITOL AVE INDIANAPOLIS, IN46202					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE	
					date will be destroyed.			
					How the corrective action(s) wi monitored to ensure the deficier practice will not recur: Medicat storage review CQI tool will be utilized weekly x4, monthly x2, then quarterly therafter, to be completed by DNS or designee threshold is met.	nt ion and		
F9999								
	Professional staff recertified, or register with applicable state. This requirement veridenced by:	ered in accordance te laws or rules. vas not met as	F99	999	F 9999 It is the practice of this provider utilize professional staff who ar licensed, certified, or registered accordance with applicable state or rules. What corrective action(s) will b accomplished for those resident	e in e laws	07/05/2011	
	evidenced by:				found to have been affected by deficient practice: The identifie			
		v and record review ensure a Licensed			nurse was removed from the schedule until licensure was upon to show as 'active'.			
	Practical Nurse (LI	PN) had a valid			How will you identify other resi			
	nursing license for	1 of 32 LPN's and			having the potential to be affect the same deficient practice and			
	Registered Nurses	(RN) reviewed for			corrective action will be taken:			
	licenses. (LPN#1)				residents receiving care under			
	Findings include:				identified staff person have the ability to be affected. All other professional staff licenses were rechecked using the PLA websit with all other staff members have	te		
	Review of licensur	e status from state			an active license.			

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/20/2011		
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN46202				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	A.M., indicated LF expired 10/31/201 LPN #1 was obse second floor Unit 06/13/2011 throug An interview with 06/20/2011 at 8:3 LPN #1's license	206/20/2011 at 9:35 PN #1's license 0. rved working as the Manager gh 06/17/2011. the DON on 5 A.M., indicated		What measures will be put into or what systemic changes you make to ensure that the deficie practice does not recur: Staff development coordinator was inserviced by DNS on 6/30/11 validating professional license hire, and when nearing expirate. How the corrective action(s be monitored to ensure the deficient practice will not re *** audit tool to be used to elicenses have been validate active prior to start of floor orientation, and then compl for each profession as expit dates near by Staff develop coordinator or designee.	on es upon etion.) will cur: ensure ed as eted ration		